INITIAL MEDICAL REQUEST
P-40 REV. 5-2001

STATE OF CONNECTICUT
DEPARTMENT OF MOTOR VEHICLES
MEDICAL REVIEW DIVISION
On The Web At http:// dmvct.org

TO: Department of Motor Vehicles, Medical Review Division, 60 State Street, Wethersfield, CT 06161-2510

TO	**PHYSICIAN'S NAME** *(Please Print or Type)*	
	OFFICE ADDRESS *(Include Zip Code)*	
RE	**INDIVIDUAL'S NAME**	**DATE OF BIRTH**
	INDIVIDUAL'S ADDRESS	

The person named above has been referred to us for driver license review. It would be appreciated if you would respond to the questions below which will aid us in the review. Your reply can be technical if necessary, as we have a Medical Advisory Board serving the Department of Motor Vehicles.

Your earliest attention to this medical request will be helpful to us as well as to the individual in question. Please fill in the applicable section below, and keep in mind that our concern is this person's ability to safely operate a motor vehicle.

SECTION A

☐ I have some knowledge of the individual and the individual's medical history. Medical matters possibly relating to driving safety are *(check all applicable boxes below):*

☐ NEUROLOGIC	☐ ORTHOPEDIC	☐ ETOH/SUBSTANCE ABUSE
☐ OPHTHALMOLOGIC	☐ ENDOCRINE	☐ NARCOLEPSY/SLEEP APNEA
☐ CARDIOVASCULAR	☐ PSYCHIATRIC	☐ LIVER/RENAL FAILURE

☐ OTHER _____

COMMENTS

☐ **This individual has NO medical matters which would affect his/her ability to safely operate a motor vehicle.**

PHYSICIAN'S NAME *(Please Print or Type)*	**OFFICE ADDRESS** *(Include Zip Code)*	
TELEPHONE NO.	**PHYSICIAN'S LICENSE NO.**	**PHYSICIAN'S SPECIALTY**
PHYSICIAN'S SIGNATURE		**DATE REPORT COMPLETED**
X		

SECTION B

☐ **I have little knowledge of this individual or the individual's medical history. I do not feel qualified to address this matter or respond to questions about this matter.**

PHYSICIAN'S NAME *(Please Print or Type)*	**OFFICE ADDRESS** *(Include Zip Code)*	
TELEPHONE NO.	**PHYSICIAN'S LICENSE NO.**	**PHYSICIAN'S SPECIALTY**
PHYSICIAN'S SIGNATURE		**DATE REPORT COMPLETED**
X		